COLORADO COMMISSION ON AFFORDABLE HEALTH CARE

11.16.2015
COPIC, Mile High Room

Meeting Summary

Commissioners present: Bill Lindsay (chair), Cindy Sovine Miller (co-chair), John Bartholomew, Jeff Cain, Julie Krow (phone), Marcy Morrison, Dorothy Perry (phone), Jay Want
Staff: Lorez Meinhold, Cally King

Meeting Summary:

I) Approval of the Minutes

A) The meeting minutes from the November 9th Commission meeting were approved.

II) Presentation from PhRMA – Tara Ryan

A) Tara Ryan, Vice President of State Advocacy for PhRMA, provided a presentation on "The Cost of Prescription Drugs in Context." The presentation provided by PhRMA can be found on the Commission website.

B) Questions and discussion from Commissioners:

1) Would we not be better off if we had more transparency? If there weren't rebates and it was just what the realistic cost would be?
   (a) There is a sensitivity to what information can be released opposed to what can be available in the market place. There are also FCC filings mandatory under federal law that not everyone is aware of.
   (b) Some have argued that formularies are based on what the rebate is opposed to the therapeutic value of drug a vs. drug b.
2) Is PhRMA in favor of greater transparency?
   (a) As an industry, we already make a lot of information available. All our companies do things differently, they report differently and there are different size companies with different capabilities. We are looking into what would make sense and how it impacts the proprietary nature of what our companies actually do.
3) Can you comment on recent increases in generic pricing?
   (a) PhRMA doesn't represent generic manufacturers and generally we don't take a position on their price increases. It probably has something to do with less competition in the generic market place.
4) One take away from the presentation is that we should spend more dollars on drugs and want to make sure we put attention on everyone so we have higher quality and lower costs. What is PhRMA doing to make sure we are providing the right drugs at right cost?
   (a) We are working with provider led organizations and trying to look at using the right drugs for the right circumstances. System is moving towards a community-based, provider-centered system. We're participating in programs all over the place. We're moving towards doctors who will be the center moving forward who connect care to specialists, hospitals, etc. We all have to work together; medicines are not the silver bullet. What we're seeing is a lot of people are facing challenges in affording medicines, which leads to more hospital care, making health care more expensive overall.

5) How long, on the average, does it take before a drug goes off patent and becomes generic?
   (a) It's about a 20 year window; 10 years for R&D, then an 8 to 10 year window.
   (b) So that's why it takes so long, in other words you're recovering cost over those 10 additional years.
6) There are many more commercials on TV from pharmaceutical companies for new drugs, some for unusual diseases, and manufacturers spend lots of money on these ads. Are the advertisements trying to attract consumers or doctors? Tell us more about the advertising since it is a huge investment.
   (a) The ads are designed to get people in to doctors who are embarrassed to talk about those things. Companies advertise during times target demographics are watching to get people in to have these needed conversations. It is an expensive part of business, but it is important to get people in to have conversations about potential problems/conditions. It doesn't mean you will get prescribed that medication but it means hopefully you will go in and have that conversation.
   (b) It seems the goal is to have consumers come in and ask for these expensive, new drugs.
7) What would PhRMA suggest be changed about Pharmacy Benefit Managers (PBMs), things like Express Scripts?
   (a) PBMs play a very significant role and are doing a great job to bring down prices. Unsure what role they should play in making drugs more accessible. The power they have and fact they openly let people know what drugs they are not covering because of an inability to negotiate is somewhat of a concern.
8) The value of all mergers and acquisitions completing or pending in United States this year is $1.99T which seems to be going up, 1 in 5 dollars is being spend on these mergers (not just PhRMA but PhRMA companies part of this). What do you think that has to do with the issue when there is less competition and how will this affect the consumer?
   (a) The reason many PhRMA companies merge is because of the pipeline and need to bring drugs to people. Without merging, they don't have the ability to get these drugs into the pipeline. Companies have to ensure something is going to hit the market at some point and need to continue revenue streams to remain viable. The value is it keeps companies solvent and going. As far as competition, they are buying a diversity of drugs/treatments/cures and not just all in one category of treatment. Not sure it impacts competition in the marketplace, it may actually increase competition.
9) Clarification question: Medicaid is required to cover all drugs?
   (a) Yes with certain exceptions.
10) With regards to rebates, PhRMA sells to Medicaid at lowest possible price – "best price" – where does that price come from?
   (a) The price is either a 23.1 percent discount on list price or something less than what the list price is on the market.
11) Question regarding market saturation of large molecule drugs (bio pharmaceuticals)
   (a) The market is not saturated in this area; it is shifting to trying to address specific types of cancer. It's looking at all the different parts of the body and different types of cancer rather than one type of medication to treat all cancers.
   (b) Are large molecule and specialty drugs the same thing?
      (i) They are not the same thing, but they commonly fall into the same categories.
12) Do companies PhRMA represents do most of their manufacturing in the United States or in other countries?
   (a) Drugs are manufactured in both the United States and outside, the majority of companies manufacture in the United States.

C) Public Comment:
   1) Debra Riswaller, health economist, Kaiser Permanente: Germaine to this conversation, I am the parent of 16 year old cancer survivor. I witnessed firsthand the implications, impact and distortions from the costs of cancer care. Have to commend the speaker on a tight, conclusive presentation but as someone who looks at this type of data day-to-day, it felt very much that you confused and confounded the prices of generic amoxicillin with the specialty drugs we're talking about. Why did you throw around 4 percent number for folks on specialty medications? Thinking about who's on specialty meds vs. what happens at the hospital and part B medications that are not part of this retail piece.
      (a) The part A and B are what make up the other percent.
      (b) Specialty care makes up the data piece. When you think about number of over 100 drugs that are FDA approved in the cancer space. I am concerned about the impact of all these cost shares on the patient side. You can't shift it all away from the patient and to the insurers or the premiums will go up, there has to be full transparency on cost of production, advertisement, R&D, etc.
   2) George Swan, retired hospital administrator: I have an anecdotal experience. I went to Kaiser and got 20 tablets that they wanted $120 for and then went to the internet and could see that across the street at Walgreens I could get the same brand drug for $18. When I was in the hospital, five drugs I was prescribed had a list price of $233K; Kaiser at the end of the day got 97 percent contractual adjustment. When you look at a number you have to be very attentive to what it is you're looking at. Just a few weeks ago, there was a big talk about drugs and CDC report that 59 percent of people in United States are on drugs; the problem is their data was taken from a survey taken in 2012. In the meantime, commercial prices are paying different prices. This all points to the need for data. These numbers presented came out of a database and all the numbers in the APCD can provide lots of info on context and indicators. It's really easy to do, yet we just don't see these numbers. We need to see these numbers to get a grip on these things.
   3) Alison Leighty, member of public: You alluded to value, curious to your perspective if there is any opportunity to share the value of drugs with patients? How do you make this meaningful and available to consumers?
      (a) We have an alliance that works on sharing this information. Better use of databases would be better across entire health care system.

III) Recommendations Document – Bill Lindsay/Commissioners

A) Payment & Delivery Reform recommendations:
   1) It seems the recommendations are limited to Medicaid and state-based programs. I would like to see the recommendations be broader - ones that businesses and others in the free market could consider.
      (a) Are we talking about mandates? What is the Commission's jurisdiction?
         (i) My understanding is these are recommendations. These don't have to be legislative bills, but could be recommendations that others can look at – suggestions.
   2) Variance to types is included in the transparency recommendations, is variation analysis or rating for provider types only included under transparency or can we add it into payment & delivery reform recommendations as well? Looking at specific procedures under an array of different providers.
      (a) Yes, it could be included here as well. John will email wording to Lorez to include in payment & delivery reform recommendations.

3) In the background section, it talks about negatives associated with Fee for Service reimbursements. We also noted in conversation that capitation didn't turn out to be perfect either. We did talk about blended approaches - game sharing, bundled methodologies, etc.
4) Under recommendations, the first one says adopt bundled methodologies for purchase of certain procedures and conditions which divides the medical market into conditions, I think it would be helpful to talk about these in long-term words instead of episodic ones.
5) For the parking lot section the Commission talked about evolving methodologies, I think it would be helpful to identify there are a series of options that need to be evaluated. As we have other conversations, we may tease out some of these things.
   (a) Bill will get wording to Lorez to include in this section.

B) Market Competitiveness recommendations:
1) There are some great tools in community (hospitals, providers, etc.) to further explore looking at cost and quality as it pertains to cost and value that we could have come in to talk about what they are doing.
2) The Commission could look at what the state is doing for employees to see if they are driving changes in price of admission. Do they offer return on investments?
   (a) John can help put together a discussion on what Medicaid is doing.
   (b) Idea of state employees is a good one; experience working with the state is that they are very thoughtful and look at information presented to them. They use the tools in front of them to make decisions. They are a really good sample to use to look at market share.
      (i) They also offer a good population to look at over time and how those decisions have impacted health.
3) The market can be an important force for changing behavior, as well as regulation, but it is important to recognize the role of the market.
4) Transparency and availability of information is critical in this process so others can look at data to make decisions.
5) As individuals face cost, they make decisions often resulting in spending less but this isn't always the most efficacious decision - including how HSA law affects these decisions.
6) There needs to be in our own presentation the balance between regulatory process and the market. There's not always discussion about looking at regulatory process in an objective way. At the same time, you cannot just look at the market process and say this is the correct way to proceed. It's very important to have those two things looked at in a balanced way.

C) Next steps:
1) We will take these comments and get into more detail of recommendation at next Commission meeting in December.

D) Public Comment
1) George Swan: Its mind boggling that the data was more than five years old from the market competiveness presentation. OECD indicators are informative information. There's another pivot table on the Commission website about the 100 DRGs at every hospital in the United States so you can look at variations. There is a reference price available comparing what hospitals charge.

IV) Commission Updates

A) Planning Committee
1) The Committee did not meet over interim because of holiday restructuring of Commission meeting schedule.
2) The Committee is working on prioritization of presentations- like todays – and is hoping to have a structured timeline of presentations to share with the Commission at the next meeting.

B) November Report
    1) The final report was sent to General Assembly on Friday, November 13th.
    2) A press release has gone out on the report and is generating interest.
C) The second Commission meeting in December is rescheduled for Monday, December 21st due to the Christmas holiday on the fourth Friday.
    1) Commission elections, as required by the bylaws, will take place during this meeting.
D) CHI hot issues in health care meeting taking place on December 14th
E) How will the Commission share our November report with the state?
    1) Bill and Cindy will present to joint health committees of the legislature in January when the legislature convenes.
F) The Commission needs to decide what we can accomplish between now and July 1st if we don't get funding and also look at it alternatively if we do get funding – what it would look like and what we would do? We do need to decide what topics we want to look at develop for the next report.
G) There is a report coming out from In Health Affairs that looks at what Colorado, and five other states, are doing in health care – can we track that and share with Commission if/when it does come out?

V) Public Comment:

A) George Swan: On the 23rd of October there was a speaker about MS that I found intriguing. One issue was data transparency and want to make point that if you go on CIVHC website and look at the data, it would be so easy to make a pivot table out of that data and make a filter by disease that would be helpful and informative to everyone looking at disease specific kinds of data. What I really want to talk about is, I think you are driving into a perfect storm that has to do with ballot initiative 69, Colorado Care. That will be center of conversation going into elections next year. Without data, people will throw around arguments all over the place. Colorado Care is relevant to me, because in 208 commission I put up a slide show on that website that is now gone. I sent a copy of the slide presentation I made about single payer user universal health care. Every single payer system is different depending on what country you are looking at.
    1) The Planning Committee had decided because this is a ballot initiative we didn't want to weigh in to take sides. Our sense was we are funded through the legislature and to take a position on a public measure isn't within our role. Maybe some of the data to discuss would be helpful, but in terms of endorsing or not it would be problematic for the Commission.